

METHADONE MAINTENANCE:
TREATMENT AS SOCIAL CONTROL

by

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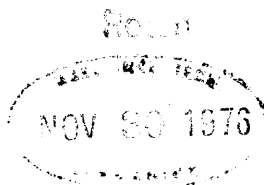
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ABSTRACT

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The growth of heroin addiction in the United States has domestic socio-economic and international political bases. The most widely used therapeutic response to the problem of addiction in America is narcotic substitution therapy, e.g., methadone maintenance. An investigation of methadone maintenance, its usefulness, policy implications and different sub-group impact is the focus of this thesis. Using my professional administrative experience, interviews, program objectives and research data, I will examine the social control potentialities of such a treatment program. Additional aspects of public policy regarding addiction treatment will be discussed as they relate to law enforcement and civil commitment. It is my hypothesis that political expediency, cost and social control are the primary reasons for the growth of methadone maintenance as a treatment modality in the United States.

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INTRODUCTION

The growth of heroin addiction in the United States has recently been substantiated by the Presidents' Domestic Council Drug Abuse Task Force.¹ An alarming trend noted in this report was the increase in the incidence* of addiction in rural areas and an entrenchment of an American-Mexican heroin distribution system. Recommendations forwarded to the President by the Task Force concerned developing aggressive law enforcement guidelines with additional personnel, an expansion of narcotic substitution therapy² and political leadership from the White House. President Ford has been slow to respond to these proposals, submitted in September of 1975. Similar proposals under the Nixon administration failed to reverse the increasing addiction problem based on the same remedial perspectives presented by his advisors. To endorse these same proposals with the same agencies, personnel, etc. will be an exercise in bad judgment. The President needs a planning period for the reorganization, re-naming, and re-financing of these proposals and another issue, such as "public safety", to which this retooling can be attached. The history of addiction in America is complex yet three interacting aspects of its treatment remain the same; politicians, programs and the police.

These three aspects of addiction treatment are important foci to public policy analysts in the drug abuse field and these aspects represent the national concern for the development of a politically expedient, cost-effective and socially-controlling treatment mechanism. At this point

*incidence - in this context refers to the number of "new" cases reported.

in American history, narcotic substitution therapy, e.g. methadone maintenance, has re-emerged as the national program for heroin addiction treatment. This re-emergence has been planned and sanctioned by the highest levels of government and has been sustained by a special interest group composed of physicians, corrections personnel and government bureaucrats who derive financial, psychological and status benefits for containing, not treating addiction.

Although all estimates of heroin addiction are suspect³, the 1974-75 estimates by S.A.O.D.A.P.* , state there are 600,000 active heroin users and 725,000 according to D.E.A.** And the number is growing. What is known is that 5 out of 10 heroin users in the United States are young, unemployed, black males, living in urban environments and no matter how many addicts there are nationwide, this proportional reality remains the same. This fact is known because these young men are the ones who are apprehended, civilly committed and/or incarcerated for violating U.S. narcotics statutes.

As a result of persistent unemployment and an extant pharmaco-mythology regarding the effects of heroin, American policy for heroin treatment has intensified the social control capabilities against the addict. This has been done at the expense of developing community-based solutions to the "grass roots" problem of addiction.

This social control capability has been placed in the interface between medicine and law. Numerous state civil commitment procedures have been enacted in recent years, which appears to be in the interest of the addict have, in effect, been a detriment to his sound recovery. How so? By developing judicial procedures that bypass the jury-trial system, encourage plea bargaining, and place the sentencing, disposition discretion in the hands of the court-appointed psychiatrists or physicians. After having been labelled "a drug addict", it is extremely difficult to convince the defendant of the difference between "quarantine" and civil commitment.

"Any social order maintains itself through the exercise of power, whether directly or indirectly. In particular, the groups or classes within a society which enjoys a privileged status as a result of the functioning of the social system seek to preserve that system in a stable equilibrium. They do this by accumulating and using power. Power is based ultimately on (1) the availability of force, (2) the existence of pervasive social attitudes or social mythologies accepted by all segments of the society that justify the actual use of force against external or internal threat. Whether a threat exists and how it is defined is normally determined by those who hold power".⁴

*Special Action Office of Drug Abuse Prevention - created during the Nixon administration and being phased out by President Ford.

**Drug Enforcement Administration - cooperative law enforcement agency receiving tacit presidential support due to recent resignation of its' director, John Bartels.

Young, black heroin users present a threat to the established order in America, whether real or imagined. The medical profession, through its' support, regulation and administration of methadone maintenance programs nationwide, has allied itself more closely with the established order and they have received the government benefits to sustain their support for a policy of narcotic substitution therapy. Being in the limelight of national "problem-solving", research grants, program directorship, developing courteous court and corrections relationships, have all played a part in maintaining a short-sighted federal policy on drug abuse treatment. Heroin addiction treatment is another case that illustrates that self-interest in the short run outweighs the common good in the long-run. The subtle growth of methadone maintenance programs, despite continuing resistance from those opposed to a therapy based on re-addiction, reflects the strong socio-political pressure for an "immediate" solution to the heroin problem.

Statement of the Problem

"In 1971, the government started a crash program to expand the national capacity to treat heroin addiction. Included in the package was a huge increase in the use of methadone, itself a powerful narcotic drug, and for the first time since 1920 the United States seemed ready to accept the validity of administering one drug to treat another".⁵

This thesis deals with narcotic substitution therapy as an implicit form of social control that operates dynamically: (1) by exercising "disciplinary" social control via medical services wherein those receiving services are encouraged to work or maintain family responsibilities no matter what subjective discomfort they may be experiencing while in treatment. This control is exclusionary in nature because it only allows those with learned work-seeking behavior, traditional family arrangements and a high tolerance for continued personal distress to continue receiving those services. If you don't meet program expectations pertaining to your recovery, you will be terminated, transferred or sent to jail.

(2) By exercising "co-operative" social control when the medical profession encourages large numbers of people into the professional management of various aspects of their lives, despite the objective discomfort the people receiving the service may be experiencing. This control is expansionary in nature because it allows adverse, objective conditions to steer people into a government-sponsored program of personal management, supported by the distribution of free narcotics. If you didn't have an addiction problem before you came to a methadone

maintenance program, daily contact with such a program will guarantee it.⁶

I am particularly concerned about this government sponsored, double-edged treatment strategy because of its specific impact upon poor white and minority communities. Methadone maintenance represents a significant departure in policy towards narcotic substitution therapy and I think it is incumbent upon policy analysts to thoroughly assess the recent origins and current implications of this change. We must determine the extent of impact and identify key actors in the implementation of this national policy.

This thesis will discuss the history of narcotics use, the implementation and development of methadone maintenance treatment, the evolution of the "black" addict and will shed some light on the exclusionary and expansionist aspects of medical service delivery and its relationship to the law. "A given agency, or even program may present exclusionary or expansionist faces at different times, in different situations, to different groups of patients. At the same time, there are certain consistent patterns in the kind of care experienced by different groups in our society - by classes, sexes, races, age groups. Thus, the different forms of social control we have distinguished are exerted differentially on different groups in society. History provides striking illustrations of the differential social control functions of the medical system".⁷

The significance of the relationship among drugs, medicine, and the law is illustrated by the variety of Congressional committees holding hearings on drug abuse.

FIGURE I

Congressional Committees Holding Hearings on Drug Abuse

Senate

Committee on Commerce
 Consumer Subcommittee
Committee on Government Operations
 Subcommittee on Executive Reorganization
 and Government Research
 Subcommittee on Intergovernmental Relations
 Subcommittee on Legal and Monetary Affairs
Committee on the Judiciary
 Subcommittee on Juvenile Delinquency
 Subcommittee on Anti-Trust
Committee on Labor and Public Welfare
 Subcommittee on Alcoholism and Narcotics
 Subcommittee on Health
Committee on Foreign Relations
Committee on Appropriations
Committee on Finance
Committee on Armed Services
 Subcommittee on Drug Abuse in the Military
Committee on Veterans' Affairs
 Subcommittee on Health and Hospitals
Select Committee on Small Businesses
 Monopoly Subcommittee

House

Committee on Agriculture
Committee on Appropriations
Committee on the Judiciary
 Subcommittee No. 4
Committee on Veterans' Affairs
Committee on Armed Services
Committee on Interstate and Foreign Commerce
 Subcommittee on Public Health and Environment
Select Committee on Crime

Source: Bureau of Narcotics and Dangerous Drugs. 1972b.

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Indeed, the role of the "drug" policy analyst will come to play a larger role in Western Hemispheric geo-politics and urban planning.

History of the Problem

Opium use was extensive before the modern era. The first written account of its use, *papaver somniferum*, appears about 3000 B.C. in Sumeria, of the Mesopotamia region.⁸ Its properties as a constipator were greatly admired as an herbal remedy for dysentery, an inflammation of the lower intestine that caused diarrhea severe enough to cause death. Later, opium's sleep-inducing properties were referred to by Roman and Greek writers such as Virgil, and Homer. Opium was frequently used by the Greeks to treat a variety of medicinal problems, including snake bite, asthma, cough, epilepsy, colic, urinary complaints, headache, and deafness. They also appeared to use the drug recreationally, and opium cakes and candies were commonly available on the street. Apparently, even in these early days of opium use, addiction to opium was common, even among high-standing military and political figures of Rome.

From the early Egyptian, Greek and Roman days through the sixteenth and seventeenth centuries A.D., the medicinal and recreational uses of opium were well established throughout Europe. Since much of the opium most likely came from the Near East, and eventually from the Orient, a bustling trade in opium existed between Europe and the East.

Before 1800, opium was available in America in its form as an ingredient of multic-drug prescriptions, patent medicines, or in such extracts as laudanum, containing alcohol, or "blackdrop", containing no alcohol. Opium was on legal sale conveniently and at low prices throughout the century. The patent medicines were sold under such names as Ayers Cherry Pectoral, Mrs. Winslow's Soothing Syrup, Godfrey's

Cordial and so on. One wholesale drug house, it is said, distributed more than 600 proprietary medicines and other products containing opiates.⁹

The use of opium as an international trading commodity for the United States didn't occur until the early nineteenth century. By 1839, the position of Americans in the Chinese opium trade was this:

"American vessels carried the Turkey drug; an American receiving ship was stationed in the outer waters; and an American firm, Russell & Company, ranked as the third largest agency for Indian opium in China. But on the other hand, Americans had lost their strategic position in the Turkish drug; American capital no longer played a dominant role in the provision of opium for American consignment and American vessels were still barred from carrying trade in opium between India and China." ¹⁰

During the 1840's and 1850's American traders and shippers were fully competing in all aspects of the opium traffic between India and China. The trade was dominated by two firms that transported approximately \$2,000,000 worth of the drug per year.¹¹ In view of the Chinese Imperial Edict of 1839, labelling opium contraband, the only difference between the policy of the United States and that of England, in practice, was the extent of participation in the smuggling. When the British refused to desist despite repeated requests, Chinese officials threw several thousand kilos of British opium into Canton harbor in a gesture of defiance rather similar to the United States' Boston Tea Party. Britain reacted to protect her interest: from 1839 until 1842 her warships blasted the Chinese coast, winning a decisive victory in what Chinese historians call "the Opium War". Although China was forced to open treaty ports to European merchants and thereby to opium imports, she steadfastly refused to legalize the opium trade. (It is clear that

the opium issue served as a political-economic wedge into a foreign market and questions surrounding its use as an addictive drug, were minimized.)

For a number of years China had posed a problem for foreign merchants. It had been virtually impossible to conduct any kind of reciprocal trade with the country because the Ching Dynasty maintained its subjects had no need of foreign goods; particularly, opium. The western merchants had to pay in silver for the tea and rhubarb they purchased. The precious metal began flowing out from foreign banks into the royal Ching coffers at an alarming rate. To restore the balance of trade, a commodity which could be sold widely had to be found.

Opium was the answer. The proximity of India and Burma gave the English a virtual monopoly on the trade and restored the balance of trade in their favor, widened their commercial sphere of influence and disabled large numbers of potentially rebellious Chinese. Britain used opium for foreign, colonizing purposes. The United States is using methadone as a domestic, neo-colonizing agent, which has as its' purpose the pacification of various sectors of the American population. Hopefully, future research will chart a different policy, one that would stress abstinence rather than maintenance.

In the United States; the medical professions' need for something that work(ed)s in a world of mysterious mortal diseases and infections cannot be overlooked as a major stimulus for the growth of the domestic opium market. The characteristics of opium and its derivatives were ideal for the patent medicine manufacturers. There were

no requirements that patent medicines containing opiates be so labelled in interstate commerce until 1906. Many proprietary medicines, that could be bought at any store or by mailorder, contained morphine, cocaine, laudanum or (after 1898) heroin. "A drug that calmed was especially appealing since physicians could at least treat the patients' anxiety".¹² The current use of methadone for treatment of addiction appears to have a similar sociological effect - calming the nations' anxiety about heroin abuse. Whatever the cause, a relatively high level of opium derivative consumption was established in the United States in the 19th century.¹³

Beginning with the Pure Food and Drug Act of 1906, the evolution of three interacting, government-supported systems has resulted in the reinstitutionalization of narcotic substitution therapy based on a recently synthesized ~~oid~~ opoid, methadone. As heroin addiction and the criminal network sustaining it are increasingly seen as a major threat to social order in the United States, a system of narco-politics has developed that includes law enforcement agencies, regulatory systems and programs to "rehabilitate" the heroin addict. During the evolution of these systems they have changed names, had cross purposes and divergent operational objectives but essentially they fulfilled the three responsibilities: enforcement, regulation and treatment.

Classical Foundations of Treatment

Serious debate regarding the clinical treatment of narcotic addiction began approximately 100 years ago. "Opiate addiction provided, then as now, one of the most baffling problems in medicine, and extensive research was conducted from the 1870's on. The two elements of opiate addiction that led to the most extensive investigation were tolerance and the withdrawal syndrome. The explanations for addiction treatment include: immunological theory based on vaccination (Dr. Giofreddi 1897); auto-toxin preparation based on hypothesized antibodies (Dr. Pettey and Dr. Bishop 1919); shedding of endothelial cells of endocrine glands leading to blocked secretions (Sollier 1898); as increased ability of the body to destroy morphine (Faust 1900); changes in protoplasm (Cloetta 1903); degenerative changes in brain cells (Wilcox 1923); and changes in cell membrane permeability (Fauser and Ottenstein 1924)."¹⁴ These explanations characterize the classical, Euroamerican definition of approach to addiction treatment.

The emphasis of treatment is physiological rather than psychological or social and places a priority on the refinement of biochemical investigation and technique.

Neo-Classical Foundations of Treatment

Technological advances in organic chemistry during this time coupled with the increasing popularity of the hypodermic needle permitted the direct injection into the body of powerful, purified substances. The "rush" of injection was to become a pleasurable phenomena difficult to describe or substitute and new approaches to

the organic, addiction-disease model of investigation had lost support by 1920, and was not resurrected again until 1962, in its new form as the metabolic theory of addiction set forth by Vincent P. Dole, M.D. "Dr. Vincent P. Dole, specialist in metabolic disease at the Rockefeller University, came to an interest in heroin addiction through his studies in obesity, which in some respects may be considered addiction to food. In 1962, Dr. Dole began planning a similar metabolic study of heroin".¹⁵

Quite ironically, as addiction-disease theory waned in impact in 1920, psychoanalysis began to be worked as an explanation of dysfunction. The etiology of addiction transferred from the body to the mind. "Psychoanalysis, an A.M.A. report explained, had shown how the subconscious life had a strong hold on our conscious behavior".¹⁶ If the addict was not normal, but a social misfit, he should be rehabilitated along the lines of vocational training and probation. Dr. Marie Nyswander, a psychiatrist, reintroduced the psychiatric approach in conjunction with the metabolic espoused by Dr. Dole and in early 1964, she was invited to join the research project on heroin addiction with Dr. Dole. In 1965 they were married.¹⁷

The convergence of these two perspectives placed the etiology of addiction with the individual. By elaborating theories of addiction based on physiological and psychological

"lack of control", the professional management of peoples lives grew. For if it could be proven that either a fault of nature (i.e. metabolic imbalance) or a sequence of poor choices (i.e. mental imbalance) were the causes of addiction then it would require further intervention by biochemists, physicians and therapists into their clients lives and the sequence of choices the clients would make concerning their lives. This theory is in opposition to a sociopathic etiology of addiction.

Drs. Dole and Nyswander agreed on methadone as the chemotherapeutic base of their narcotic substitution regimen with ancillary social and psychiatric services as a required part of program treatment. Methadone is a synthetic opiate, invented by the Germans during World War II when normal supplies of opium were cut-off.¹⁸ Methadone is as potent a pain killer as morphine and heroin, and its other effects are similar as well. All three drugs, for major purposes, are inter-changeable. All are highly addictive. If a person is used to taking anyone of them, the body and mind rebel against withdrawal, though how much is physical and how much psychological has been debated for a century.¹⁹

Modern Justification of Chemotherapy

The use of methadone for the treatment of addiction is not a breakthrough but a re-discovery of faulty logic.

It must be remembered that opium addiction treatment in America has a developmental history as follows:

- 1) Opium smoking and eating was treated with morphine injections.
- 2) Morphine addiction was treated with repeated, sometimes gradually reduced herion injections.
- 3) Herion addiction is now being treated with methadone, a synthetic, oral opoid.
- 4) Methadome addiction will be treated with 1-alphaacetyl-methadol or with the newer narcotic anatagonists. ²⁰

Opium → Morphine → Herion → Methadone → Laam ?

The introduction of each chemotherapeutic agent, e.g. morphine, herion, etc., was based on speculative claims of cure, substantiated by anecotal cases and ever growing estimates of the size of the problem. Essentially, narcotic substitution therapy is justified periodically for the following reasons:

- 1) With addicts on legal opiates, law-enforcement agencies, courts, and prisons can concentrate on offenders who supply opiates to non-addicts.
- 2) Society is far better off when addicts are on legal rather than exorbitantly priced illegal opiates. Addicts themselves are better off on a low-cost, legal medicinal opiates than on adulterated, and contaminated street herion.
- 3) It is economically disastrous and morally indensible to permit the American system of herion distribution to continue to flourish and enrich itself - without trying to find an alternative.
- 4) Even though serious flaws in the new system of dictribution might develop, the new system could not possibly be worse than the existing herion black market.

Wether such justification meets the needs of the addicts is still unanswered and from the basis of these statements it appears that a policy of "Containment" predominates a policy of "treatment".

* Monetary impact - e.c., theft, time loss from work, social welfare costs, lost tax revenue, etc.

For if the development of programs is founded on the premise that the police need assistance, society will fare better, that the monetary impact will be lessened and that the government dispenses better drugs more systematically, then who is the program treating - the addict society.

Problem of evaluation

The evaluations of methadone maintenance have been subject to a kind of criticism that suggests the lack of successful consensus both on the objectives of the program and on appropriate measures of "success". Donald Louria, president of the New York Council on Drug Addiction, notes that the data on which evaluations have been based are largely supplied by the programs themselves, with few mechanisms for outside verification. Concerned with their public image (which may affect their continued funding), many rehabilitation programs are wary of outside evaluation. Others have had no resources for compiling systematically the data needed for evaluations. Also the two primary measures of success have been criticized. Using the declining rate of arrests is questionable since police are often willing to defer arrangement of an addict if he is in treatment. Similarly, the retention rate is labelled meaningless by some critics given the continuing physiological dependence on methadone.²¹ The fact that methadone patients are usually older than the average addict, and close to the age at which it appears to be easier for addicts to abstain from drugs without methadone, has caused some skeptics to question the actual effectiveness of the program. This maturation factor has significance both for the prospects as well as the actual effect of the methadone programs. Evidence has been provided by a number of studies showing that the process of "maturing out" may be reality

for some 23 percent of the known addicts in New York City. The mean age of maturation was 33.8. ²² Another objection to methadone maintenance is that a technological solution does not confront the real social and/or psychological problems that lead people to addiction in the first place. It is my view that maintenance is no more than a recycled, chemotherapeutic justification for the expansion of addiction. A "simple" medical approach to a complex social, political, and psychological problem. It is a short-sighted, patchwork, treatment based on a principal of least effort, and one which deepens prevailing mystifications by perpetuating the drug means for the solution of human problems. I am not alone.

Dr. Daniel Casriel, the psychiatric superintendent at the Daytop Village in New York City, calls the methadone treatment "malpractice and a cop-out," a cheap substitute for an expensive habit of self-indulgence." When a narcotic is made free and available by government agencies it can only increase and encourage the further use of drugs". He regards the physician prescribing methadone as another pusher: If we can't lick em, lets join'em." ²³

In a letter to the editor,

"The optimal dosage and duration of medication are important subjects medically, economically, and as Dr. Dole suggests politically.

In his initial report in The Journal (193:646), 1965, Dr. Dole promised control studies 'with social support but without medication'. Not only has this not been accomplished by his group, but control studies of different dosages have not been reported by them. In the absence of controlled studies, the bias of the researcher, reinforced by patient manipulation too often invalidates the results.

This I believe, has been the fundamental weakness of the many clinical reports that Dr. Dole and his co-workers have offered. Thus we are in a situation where after more than eight years of widespread experience in methadone maintenance therapy in thousands of patients, the vital questions of optimal dosage and optimal duration of pharmacological treatment are still unresolved". Robert C. Wolfe M.D. 24

Further evidence of Dr. Dole's insensitivity to new information related to dose is apparent in his refusal to accept findings that appeared in the proceedings of the 5th National Conference on Methadone Treatment, N.A.P.A.N., 1973 pp. 972-9 by G.J. Berry in his article entitled, "Dose related response to methadone: Reduction of maintenance dose" and Avram Goldstein and B.A.-Judson, Efficacy & Side Effects of three widely different methadone doses- (pp. 21-40) which definitively state that low doses (30-50 mg) are as effective as the first-year blackade doses recommended by Cushman and Dole (100-130 mg/day).

The criticism only begins here. It goes on the 2nd Report of the National Commission on Marijuana and Drug Abuse, March 1973, U.S. Government Printing Office, Washington D.C. 20402 in Drug Use in America, Problem in perspective, states unequivocally:

"The Commission has carefully scrutinized these claims. [methadone maintenance's effectiveness]. In general, they have been based on the reported findings of a limited number of quasi-experimental studies (mostly before-after comparisons); the deficiencies in research design, sampling techniques, analysis and interpretation of the data significantly limit the reliability and validity of the conclusions and the inferences drawn therefrom.

In fact, we have not found sufficiently responsible research to conclude that any of the various treatment modalities regardless of type, actually reduce crime. (p. 176-66)

Because of methodological discrepancies- no dosage control, no monitoring and/or supervision of program administration, no standardization of point in treatment where measurements are taken, computation of program admissions and drop-out data (early dropouts simply not counted), although counted for budgetary and accounting purposes, and the same with readmissions, leads one to the conclusion that what is perceived as a triumph of a particular treatment modality may be for the most part a simple statistical artifact. (p.179).

Other problems related to methadone maintenance include;

- (1) the addicts unwillingness to give up the heroin euphoria.
- (2) unreadiness to lead a planned, structural life.
- (3) fear of being controlled by or too dependent on clinic.
- (4) sexual impotence caused by or intensified by methadone.
- (5) intractable insomnia leading to abuse of sedative and hypnotic drugs.
- (6) socialization problems.

These are examples of subjective discomfort that continued narcotic substitution therapy clients experience. Very little has been done to rectify the impact of these "persistent" side effects of treatment.

Program Development

Methadone maintenance was introduced as a 20th century technological "fix". "Developed at a time of extraordinary public pressure to 'solve' the problem of addict crimes, methadone maintenance is an attractive solution:

(1) it is cost-effective, being the cheapest known form of treatment (2) yields visible clinical results in providing humane relief to addicted persons, (3) it meshes well with assumptions concerning the efficacy of technology, the widespread tendency to regard all problems as amenable to technological solutions." ²⁵

" Contributing to the controversy surrounding the methadone programs are many ethical, social, and political questions. What is the medical and moral justification for perpetuating and individuals dependence on an addictive drug, for focusing on symptomatic changes in behavior while ignoring the source of addiction? How do the agencies responsible for regulating and controlling the use of a new medical technology deal with an often vague distinction between treatment and investigative research? Many of these issues involve questions of power and social control. Therapy, by definition, is context-bound, involving a societal definition of deviance, the goal is to return a situation to a pre-conceived notion of 'normalcy' ". ²⁶ And that is exactly what's wrong with a program designed to rehabilitate. Its function is to re-program people back into the same discriminating, career limited, institutionally-prejudicial system that was responsible for their addiction in the first place. The ultimate authority of the addicts' treatment lies in the hands of that white, upper class medical and political elite that does not know the lack of opportunity the addict experiences daily. Interest in methadone maintenance and drug abuse emerged not as the result of a rekindled medical interest only, but as a political interest as well.

The White House strategy developed to conduct a war on drug abuse

* According to Allan Parachini, The Village Voice, October 24, 1974, in an article entitled, The Wrong War.

involved a number of familiar people. Nixon initially assigned Egil "Bud" Krogh* to the job of stopping crime in the Washington, D.C. area. "The link between the D.C. crime rate and the heroin war was a 1969 study of inmates booked into the District jail, which showed that about 45% of criminal suspects were heroin addicts. A 1972 count put the addiction figure at 47 per cent and non-addicted users at 21 percent. In addition, a study of D.C. crime by police chief Jerry Wilson recommended vastly increased drug treatment facilities. The die was cast." Krogh was the White House liason to the D.C. government and was in charge of overall supervision of the evolving administration drug effort as an adjunct duty. Using opinion poll results showing drugs as one of the three or four most pressing issues, the drug war became part of the Nixon law and order campaign. According to Krogh, Nixon wanted tough, mandatory minimum prison sentences (similar to statute changes instituted by Gov. Rockefeller in New York), but Attorney John Mitchell, of all people, talked the president out of it. In an attempt to cope with the problem and realize political results as well, Nixon awarded the highest priority to the developing drug action. The result was the White House Special Action Office for Drug Abuse Prevention (SAODAP), whose objectives, according to Krogh, was crime prevention and control. "On June 10, 1971, just a week before the Nixon declaration of a war on drugs, the president called a White House meeting of Krogh, H.R. Haldeman, White House aide Jeff Donfield, and Dr. Jerome Jaffe, the Illinois drug treatment official who became the first head of SAODAP." The future domestic and international strategies for drug and crime control were discussed.

*Krogh was brought to the White House at John Erlichman's request.

The expansion of methadone maintenance program capacity was an integral part of that discussion. "(And) if the District of Columbia crime was what got Nixon initially into drugs, it was Vietnam, according to Krogh, that turned the problem into an emergency." Nixon's drug war is a good example of how foundations for policy were built on the drifting sands of political expediency. Not only heroin use by American soldiers in Vietnam was eroding the drug wars' public image but the publishing of Alfred P. McCoy's doctoral dissertation, The Politics of Heroin in Southeast Asia, which clearly implicated the C.I.A. and Air America with the international narcotics smuggling clique of the Golden Triangle*, did not help.

Methadone maintenance is a procedure through which an addict is provided with daily, oral doses of methadone, usually in a closely-controlled clinic setting. The addict receives an increasing amount of methadone until he reaches a dose regarded by the physician as stabilizing; that is sufficient to provide a cross-tolerance effect which will block the euphoric effects of heroin should the addict try to return to his former habit. This dose may vary from a low of 10 mg. to a high of 120 milligrams per day. Once the addict is brought up to the desired level, he receives an amount daily for an indefinite period of time. As long as he is on methadone, he will not feel the "rush" or euphoria from heroin, and thus the reward of a "fix" is removed. Methadone is narcotic specific and therefore doesn't preclude the use of other psychoactive drugs such as minor tranquilizers, alcohol, cocaine, barbiturates or amphetamines. The actual effectiveness of this treatment technique varies considerably among individual patients. It is usually

*Golden Triangle-is comprised of Burma, Thailand and Laos, estimated to be the source of approximately 30-40% of the heroin that reaches the U.S.

explained in terms of its physiological impact in reducing narcotic drug hunger.²⁶ But some researchers, noting how little is known about the chemical basis of addiction, prefer to explain methadone in terms of conditioning; by abolishing the pleasurable effect of heroin, it weakens the conditioned behavior pattern that drives the addict to continued use of heroin. Coupled with this is the idea of "metabolic" imbalance. However, methadone does not dull depression or anxiety as does heroin, nor when taken orally does it provide the satisfaction that derives from the ritual of "mainlining" (although when mainlined it has similar euphoric effects). Thus it can facilitate behavior change only an addict who is highly motivated to discontinue the use of heroin. No one has speculated what per cent of addicts are in this category.*

Methadone to maintain an addict is for several reasons a more satisfactory treatment than the heroin maintenance system which has been used in Great Britain. Unlike heroin, methadone is absorbed effectively through the gastrointestinal tract and is effective for a full twenty-four hours. It is, therefore, administered orally only once a day. There also appear to be fewer "ups and downs" with methadone than with heroin; the addict does not require increasingly larger doses to remain comfortable. Methadone withdrawal symptoms develop more slowly and last longer than heroin withdrawal, but they are less intense if gradually reduced. Abrupt termination of methadone will precipitate severe withdrawal symptoms similar to the ordinary narcotic

*Methadone maintenance may eventually attract 40% of the heroin dependent population. (McGlothlin et al 1972) This is highly speculative and doesn't rank motivation for treatment.

narcotic withdrawal syndrome. However, the possibility of complete withdrawal remains uncertain. For example, Dr. Dole withdrew methadone from 350 patients to find that their heroin hunger returned. Others have reported some success with highly motivated addicts if withdrawal is eased with decreasing amounts of methadone and continuing personal support.²⁷

As far as is known, opiates, including both methadone and heroin, if taken in controlled doses, cause few physiologically debilitating side effects, though there are individual differences in the reaction to all drugs. Yet, side effects that have been attributed to methadone include weight gain, constipation, increased intake of fluids, delayed ejaculation, increased frequency of urination, numbness of hands and feet and hallucinations.²⁸ Dr. Joel Fort, Former consultant on drug abuse to the World Health Organization says: Heroin is a hard drug only in the sense that the addiction is very strong. Chronic, excessive use of heroin produces no physical damage at all. But the long-term physiological impact of extended methadone treatment remains unknown, and there is only limited scientific understanding of its effects on the performance and behavior of patients.

The idea that maintenance on a narcotic is a good way to deal with narcotic addiction is not a novel one. England has used such a system for half a century and the United States had morphine maintenance clinics in several cities between 1914 and 1923. Most drug authorities, then and now, think the American clinics worked well in handling the difficult problems created by the Harrison Act, which first outlawed non-medical narcotics use. But in both instances, neither the scope or the numbers compares to the situation in the U.S. today.

The legality of methadone is its major advantage over heroin. The most serious physiological problems faced by heroin users are due to the irregular availability and poor quality of the drug. The unsanitary conditions of "mainlining" heroin cause diseases such as serum hepatitis and dermal abscess. The acceptability of methadone and its administration in the regulated setting of a medical clinic in which potency and quality are controlled minimizes dangers of disease and overdose. Legalized distribution of heroin in medical clinics would have this same advantage and some authorities propose this practice to meet the needs of addicts unwilling to accept methadone treatment.

PROGRAM EXPANSION

Methadone has been prescribed since 1948 to facilitate the detoxification of heroin addicts. But only since 1963 has methadone been used for the maintenance treatment of heroin addiction. The "effectiveness" of methadone as a maintenance narcotic was discovered accidentally. Marie Nyswander, M.D., a psychiatrist, and Vincent Dole, M.D., an internist, both from the Rockefeller Institute and Beth Israel Medical Center, were looking for ways to relieve drug craving. In October 1963, they prescribed large amounts of methadone to two patients who had been taking such high doses of heroin that they were continually drowsy. The methadone was provided to reduce their heroin need, but striking changes in the behavior of the patients led to further exploitation of this procedure through a series of planned investigations.

In New York State there had been no extensive research in this area until February 1962, when the Medical Society of the County of New York ruled that physicians who participate in a properly controlled and supervised clinical research project for addicts on a non-institutional basis would be deemed to be practicing ethical medicine.²⁹ The ruling made possible systematic clinical investigation of the use of methadone and a program involving six patients began in January, 1964 at Rockefeller University.

"By March 1965, Drs. Dole and Nyswander had the use of four rooms in the Morris J. Bernstein Institute of the Beth Israel Medical Center and they began to admit patients. Two years later there were 350 addicts in the program and many on a waiting list. By October, 1969 the number of patients in the Bernstein Institute increased to 719 and dispensing clinics had been set-up throughout the New York City area with a total of 1,744 patients. As of March 31, 1971, the program had expanded to include 82 ambulatory (out-patient) facilities and thirteen inpatients facilities in New York and Westchester County with 7,000 patients and an admission rate of about 700 patients per month. And, by March 1972 it was estimated that 65,000 throughout the country were maintained on methadone." (30)

By early 1973, 73,000 addicts were in methadone programs. After that the census rose slowly, leveling off at about 80,000, a figure which, according to government estimates, represents a little less than 20 per cent of the addict population. Another 45,000 are in treatment other than with methadone, 85,000 are in jail and 250,000 are on the street*³¹

And if this isn't enough the New York Times, May 8, 1975, page 41, reported by David Bird, that Dr. Bellin, Health Commissioner, is considering legislation, which has been under consideration for more than a year, was prompted by charges of abuse by the private clinics. Dr. Bellin said the city programs cost more because of the conscientious providing of auxiliary services. He said the services were not being given at many private clinics which were just "skimming off" the profits after dispensing methadone. Twenty-four of the methadone clinics in the city are private, thirty-nine are run by the city and seventy-nine are run by voluntary non-profit institutions. What a way to make a dollar. Readdict people and charge them on a weekly basis which can be billed to Medicaid. And they accuse drug pushers of being unconscionable.

Methadone clinics may inadvertently be responsible for abuse. The availability of the quick solution minimizes the risk of addiction and may encourage drug experimentation. Furthermore, Donald Louria claims that because of the low quality of street heroin, many users are not actually physiologically addicted. A program risks, then, turning nonaddicted heroin users into methadone addicts. This possibility is suggested by a study of admissions

to the National Institute of Mental Health clinical research center at Lexington-

*I consider these estimates a little low because Dr. Jaffe stated at the Fourth National Conference on Methadone Treatment that I attended in March, 1973 held in Washington, D.C., that approximately 85,000 people will be on methadone by early 1974 and at its present rate of growth, it must surely be more than 90,000 as of June 1975. Nor is any indication made as to whether the source programs involved with the data generation are public or private or both.

ton, Kentucky. Out of one hundred consecutive admissions of opiate users in January 1971, forty-three showed no actual physical dependence when tested. There are no adequate diagnostic techniques for determining the extent of addiction or the tolerance to narcotics.³²

United States Congressman Charles B. Rangel has observed that methadone as a cheap solution seems to be a therapy designed for blacks and an example of how special programs are used in dealing with the poor. In public hearings he questions what would be done if a more affluent socioeconomic group were affected by a similar problem, and he advocates limiting the expansion of methadone.³³

Rangel continues: "Walk along any street uptown and you'll see Harlem's great addict army - slumped over in doorways, stumbling along in a trance, nodding in front of bars, standing in the cold without enough clothes on. Chances are you'll also see another all too familiar Harlem scene: the dope pusher who sets up shop on a street corner and deals like he has a license - for all practical purposes he does, when one considers 'license fees' paid to the local police precinct; whole neighborhoods have been completely abandoned to junkies."

In December 1971, a national conference of black physicians and health care workers, sponsored by two medical colleges, Howard and Meharry, concluded that the methadone maintenance program was "an attempt to control large segments of the non-white population through submissive behavior."³⁴

But most devastating of all is the effect heroin has had on our young - the hope of the black nation. Why the word "genocide"? The dictionary definition of genocide is the planned extermination of a racial group. In the case of heroin, if physical extermination is not the goal, political, social, and cultural extermination seem to be the approaching result.

National program expansion-Medical and Legal Initiatives

the impetus for the expansion of methadone maintenance as a treatment mechanism came from two specific professions- medicine and law.

"Several programs outside New York started when a local, private undertaking by an internist in private practice, Dr. Robert A. Malansky, was initiated. By the time he had 39 patients on the program, however, he found he had too little time left for his regular practice. Accordingly, he stopped further private enrollments, and launched a second program under the auspices of Mount Sinai Hospital in Minneapolis. A third program was later established in that city.³⁵

In New Orleans, it was a municipal judge, Andrew Bucaro, who spearheaded methadone maintenance.³⁶ This is an example of the legal interest in the creation and spread of this type treatment program:

Judge Bucaro, like many others on the bench, grew weary and angry at the steady parade of addicts before him - few of them for the first time or even second time. When he heard about methadone maintenance, he began phoning physicians in a search for one who would try it in New Orleans. After eight consecutive rebuffs, he reached Dr. James T. Nix, who already had one patient on methadone in his private clinic. The two Nix clinics now have more than 160 New Orleans patients coming in for methadone daily, and six other methadone maintenance clinics (including one for women run by a Catholic nun) are now operating. By the fall of 1970, the eight New Orleans clinics were treating about 1,200 patients.³⁷

And it spreads.

COST EFFECTIVENESS

Since the cost of methadone itself is trivial - ten cents per day - the cost of a program depends primarily on the range of auxiliary services.* Dr. Dole estimated in 1970 that a budget for comprehensive treatment, including not only methadone but all of the auxiliary services costs \$1,500 the first year, \$1000 the second year, and \$500 a year thereafter. Thus it is more attractive in terms of cost per patient than any other form of treatment currently in use clinically. "Only 3 per cent of the addicts expressed a preference for a 'therapeutic community' experience of the Synanon or Daytop type in Chicago's voluntary court program".³⁸

Under the Nixon administration, we have witnessed the dramatic increase in Federal expenditures for all aspects of dealing with drug problems from a fiscal 1969 budget of \$82 million to an estimated \$760 million for fiscal 1974 with the attendant creation of new agencies at all levels of government and reorganization of functions. And now, there seems to be a generally held consensus - at least among Federal officials - that the Federal drug war allocations will level off, and probably decline over the next few years. "Yet, despite the concern being voiced for the dangers inherent in "get-tough" measures, the proposed Federal fiscal 1975 budget projects a 40% increase in drug law enforcement monies, while there will be a decrease in monies for treatment and rehabilitation."³⁹

*Relative treatment costs;

Hospital	\$21,000/year
Prison	9,000
Halfway house	4,500
Detoxification	
outpatient	2,200
Outpatient Methadone	
Maintenance	1,700

Source; White Paper of Presidents' Council
as cited, p. 71

Such financial circumstances as these give an overriding advantage to the program which can demonstrate a lower cost per patient.

Alvin Reinford, executive director of the Federation of Addiction Agencies, the largest drug-free program operating in Brooklyn, stated that while drug-free programs are being killed off....methadone maintenance programs are thriving and growing at an alarming rate. He made the statement in the face of threatened cut off of city funds. Indirect and direct pressure will be brought to bear on maintenance program administrators to maintain or expand their census tract to retain the same level of funding. Questions surrounding individual detoxification may be affected.*

Maintenance programs were also given two additional aspects of expansionary latitude recently. First, during 1972 the F.D.A. imposed federal guidelines under which methadone would be regarded no longer as an investigational drug but as a "legitimate medical treatment".⁴⁰ Programs will be expanded so that all those who had been unable to find treatment can enroll, but much stricter controls would be established through a closed (exclusionary) system of distribution limited to licensed practitioners. In fact, this greatly increased F.D.A. control over methadone use, removing the drug from pharmacies and from private practice, and limiting its use to F.D.A. approved and supervised programs. The government as Pusher. Second, age is one major methadone issue on which there is as yet no consensus. Originally designed for addicts

*This article in the New York Amsterdam News of Saturday, January 18, 1975 is an example of the basic funding conflict nationwide. Pressures to show continuing patient participation, community involvement, "success" however it is measured underscore the dynamics of the life and death struggle being waged by drug-free versus drug-dependent programs. Free narcotics must win in the short run.

25 and over, with a verifiable 4 year history of addiction and several attempts at treatment in other modalities, according to Dr. Dole, "We have had parents and ministers come to us and...say, 'Does this boy have to go to jail and suffer two more years of addiction which he already is in? He's been in jail.' So I think that the answers as of today is that if a person is unmistakably an addict with an uncontrollable daily heroin habit and already into and on his way into more trouble for two years, then he is sufficiently into it to justify methadone treatment."⁴¹ This is the justification for maintaining addicts as young as sixteen. Lowering the age limit has an expansionary effect upon the program. And Dr. Dole has maintained some addicts this young already. The question of profit is never mentioned. That's business, not medicine.

Private maintenance programs' criteria for admission only require 2 years drug use (verified?) and only one previous treatment failure. Intake workers solicit patients from public program waiting lists. The patient enrollment is white 88%, 9% black, 3% puerto rican and approximately 25 years old. The fact that patients are expected to pay for their medication acts as a stimulus to find employment.⁴² And if private clients can't work, they can bill either General Relief or Welfare for their clinic fees. Here we have a clear example of government sponsored drug dependence in the private sector of the economy. More elaborate arrangements can be made in the event that a client's health insurance covers addiction treatment. Only certain segments of the addict population can afford to maintain such coverage or pay cash for this other "level" of care. This group of pampered clients consists of physicians, nurses, politicians, their wives and the rich.

EVOLUTION OF THE BLACK ADDICT

Several characteristics of opiate use under 19th century conditions of low cost and ready legal availability are quite surprising. Most users of narcotics were women. Two studies, one in Michigan (1878) and another in Iowa (1885), showed female opiate users as 61.2% and 63.8% respectively, of the samples. The widespread medical custom of prescribing opiates for menopausal and menstrual discomfort and the many proprietary opiates advertised for "female trouble", no doubt contributed to this excess of female users.⁴³ A second interesting fact was the age of the users. An 1880 Chicago survey showed an average age for males of 41.4 years and for females of 39.4 years.⁴⁴ The 1885 Iowa survey similarly noted that the majority of opiate users "are to be found among the educated and most honored and useful members of society".⁴⁵ So what we had was a situation where white parents, of middle and upper class families,³⁶ in their middle ages were using opiates in a relatively unencumbered environment. I will note that there is no evidence of any disproportionate use of opiates among black people during the 19th or early 20th century. Surveys made in 1913 in Jacksonville, Fla., and throughout the state of Tennessee in 1914, turned up a much lower proportion of opiate users among blacks than whites.⁴⁷

Unfortunately, the addict profile was about to change, and Booker T. Washington had a premonition about the change that was to occur. In a statement written to the American Medical Association (Journal of American

Medical Association February 21, 1914 Vol. LXII No. 8 pg. 641) for the National Conference on Race Betterment, Mr. Washington wrote:

"In order to be most helpful to it (the Negro race), the white race should try to keep most of the Negro race in the country districts, out of contact with large, complex city life. The next thing is to keep whiskey away from my people. I would also ask you to use your influence to keep patent medicines away from my race. These three things will help my race". None of his foresightful advice was taken. The high proportion of black people among known opiate addicts during the 1950's and 1960's is a quite recent development, visible chiefly since World War II.

From Figure II, we observe that black drug offenders remained a numerical minority, at least through the 30's, although from 1920 on there was a significant increase in their relative likelihood (compared with whites) of becoming offenders. The table shows the F.B.I. statistics from 1933 to 1955, which indicates that beginning in 1950 blacks were a majority of offenders and they remained this way until 1960. At that point there is evidence of both an absolute and relative increase in white drug use (primarily heroin). This means that blacks continue to be more likely to be arrested for drug offenses than whites.⁴⁸

The development is an important one to record for we have become accustomed to thinking of heroin-use as primarily an inner-city black problem, when in fact this has been a rather short-lived (1950-1960) feature of the more stable class phenomena-as short-lived, for example as the Jewish heroin problem (1910-1920).⁴⁹

FIG. II

TABLE 8
 PERSONS CHARGED WITH VIOLATION
 OF NONFEDERAL NARCOTIC LAWS BY RACE

Period	White	Black	B/W Ratio	Mexican	Chinese
1933	2,251	362	.16	n.a.	n.a.
1934	2,327	511	.22	323	621
1935	2,178	496	.23	307	581
1936	520	148	.28	281	698
1937	657	202	.31	303	609
1938	880	190	.22	291	444
1939	1,171	252	.22	263	457
1940	3,118	968	.31	300	527
1941	1,540	543	.35	195	267
1942	694	244	.35	n.a.	165
1943	806	347	.43	n.a.	167
1944	1,009	517	.51	n.a.	186
1945	1,205	567	.47	n.a.	130
1946	1,773	903	.51	n.a.	96
1947	2,167	1,120	.52	n.a.	62
1948	2,876	1,776	.62	n.a.	107
1949	3,620	2,677	.74	n.a.	135
1950	3,969	4,262	1.08	n.a.	175
1951	5,873	6,697	1.14	n.a.	227
1952*	1,635	1,447	.89	n.a.	7
1953†	2,563	3,018	1.12	n.a.	27
1954††	2,371	4,154	1.75	n.a.	25
1955	2,462	4,363	1.77	n.a.	22

* Arrests for 232 cities over 25,000 in population. Prior to this no estimate given of the number of agencies forwarding fingerprint records.

† Arrests for 1,174 cities over 2,500 in population.

†† Arrests for 1,389 cities over 2,500 in population.

Source: Uniform Crime Reports.

Having grasped the class phenomena, the disturbing fact is that the ethnic dimension of heroin addiction may be stabilizing. Using Table 2, figure III, we see that the greatest number of addicts live where there is the highest concentration of blacks, relative to our representation in the over all population.

In addition, the heroin use that is spreading is in those rural areas that have traditionally had high concentrations of blacks. Using table I, figure IV, we see the increase in the rate of active narcotic addicts in 35 leading cities.

For the period 1969-71, the addict population increased by approximately:

20 times for Charlotte, N.C.
10 times for Dayton Ohio
10 times for Jacksonville Fla.
5 times for Berkeley, Calif.
5 times for Richmond, Va.
5 times for Louisville, Ky.
30 times for Norfolk, Va.
3.5 times for Detroit, Mich.
.5 times for Miami, Fla.

And S.M.S.A. population estimates for these areas did not expand proportionately for this two year period. Although larger city increases are relatively smaller than rural "cities", there is obviously a larger absolute increase. Further, nowhere is there an indication of a decline of similar proportions, least of all in the black community.

What brought about the change in the addict population? the major cause of the changed addict profile was the Harrison Narcotics Act of 1914, which was basically a tax act (or law) requiring persons authorized to handle or manufacture drugs to register; pay a fee, and keep records

TABLE 1

Leading Cities in Active Narcotic Addicts

<u>35 Cities</u>	<u>1967</u>	<u>1968</u>	<u>1969</u>	<u>1970</u>	<u>1971</u>
New York, N.Y.	30,543	29,990	30,119	27,097	32,635
Detroit, Mich.	1,642	1,842	2,587	4,022	5,842
Chicago, Ill.	6,489	5,944	5,633	4,719	3,728
Washington, D.C.	1,106	1,162	1,636	1,743	2,409
Newark, N.J.	1,004	1,216	1,560	2,404	2,372
Philadelphia, Pa.	1,296	1,452	1,502	1,406	1,732
Los Angeles, Cal.	1,997	2,124	2,164	1,990	1,460
Baltimore, Md.	1,348	1,765	1,843	1,607	1,393
Paterson, N.J.	423	529	763	1,010	1,364
San Francisco, Cal.	324	491	705	695	1,003
Buffalo, N.Y.	555	643	771	755	944
New Orleans, La.	353	500	714	708	821
Norfolk, Va.	24	66	193	309	741
Boston, Mass.	311	315	302	433	656
Miami, Fla.	109	99	228	298	515
Phoenix, Ariz.	171	221	314	382	487
San Antonio, Tx.	530	558	549	518	414
Columbus, Ohio	177	135	146	156	368
Louisville, Ky.	43	148	234	272	360
Richmond, Va.	49	47	83	144	354
Seattle, Wash.	104	116	297	343	350
Cleveland, Ohio	102	90	77	100	349
Berkeley, Cal.	76	111	173	243	310
New Brunswick, N.J.	50	81	133	230	310
San Diego, Cal.	550	484	397	298	294
Pittsburgh, Pa.	232	200	260	226	290
Elizabeth, N.J.	158	192	269	268	267
Jacksonville, Fla.	28	29	27	27	245
Dayton, Ohio	18	27	27	16	230
Oakland, Cal.	339	351	329	280	213
Albuquerque, N.M.	469	436	361	264	211
Fresno, Cal.	158	150	130	155	202
Bridgeport, Conn.	110	174	239	240	192
Charlotte, N.C.	8	7	5	39	178
Dallas, Tx.	45	106	113	176	177
Total for 35 cities	50,941	51,801	54,883	53,573	63,416
Total active addicts	62,045	64,011	68,088	68,864	82,294
Addicts in 35 cities as percent of total active addicts	82.1%	80.9%	80.6%	77.8%	77.1%

Source: Bureau of Narcotics and Dangerous Drugs, 1972 b.

FIG. IV

TABLE 2

Estimated Number of Narcotic Addicts

The national estimated narcotic addict figure is 559,224 (as of December 31, 1971).*

<u>City</u>	<u>Estimated addicts</u>	<u>State</u>	<u>Estimated addicts</u>
Baltimore	9,609	Arizona	3,143
Boston	5,900	• California	50,035
Buffalo	2,307	• Florida	11,919
• Detroit	30,311	• Louisiana	6,339
Miami	5,860	Massachusetts	13,157
New Orleans	3,007	• Maryland	23,045
• New York	302,547	• Michigan	31,364
Norfolk	3,070	Mississippi	1,919
Philadelphia	8,150	• New Jersey	21,522
Phoenix	1,672	New Mexico	1,705
• San Francisco	10,414	Nevada	1,146
• Washington, D.C.	14,634	• Pennsylvania	25,395
		South Carolina	5,414

Note: Those states and cities not listed lacked sufficient base data for an accurate estimate.

Source: Bureau of Narcotics and Dangerous Drugs, 1972 b.

* Statistics drawn from BNDD Director's Report.

of all "narcotics" in their possession. Cocaine was listed as a "narcotic" also.*

*NOTE: The inclusion of cocaine a "narcotic" under the law despite the obvious fact that it is a stimulant is attributable to Southern political pressure. "The fear of the cocaineized black coincided with the peak of lynchings, legal segregation and voting laws all designed to remove political and social power from him. Fear of cocaine might have contributed to the dread that the black would rise above "his place", as well as reflecting the extent to which cocaine may have released defiance and retribution. Anecdotes often told of super-human strength, cunning, and efficiency resulting from cocaine. Newspaper reports of "cocainomania" among Negroes also spread rumors, in D. Musto, The American Disease pg. 7-8.

The passage of the Harrison Act caused considerable concern among physicians about what limitations the law might place on their privilege to prescribe as they saw fit within the bounds of accepted medical practice. On the other hand, one part of the act helped allay their fears, stating "Nothing contained in this section (prohibiting distribution of opium, opiates, and cocaine) shall apply: to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist or veterinary surgeon registered under this act during the course of his professional practice."⁵⁰ But the physician's privilege to prescribe narcotics for his addicted patients ceased abruptly after Treasury Decision 2200, announced May 11, 1915. The decision stated that physicians' prescriptions for narcotics for addicts must show decreasing doses over time; were this not the case, the physician would be presumed to be violating the law.⁵¹

The only question publicly debated with reference to narcotics was how to control, not (as in the case of liquor) whether to control.

But there were some physicians who rejected the attitude that addicts

should be shunned. Without doubt some disagreed because there was a good income to be made from them. Others saw no harm in maintenance (e.g. narcotic substitution therapy) if it would enable a fairly normal life for a doubtfully curable individual.⁵² For all intents and purposes, opiate use was made illegal and the care of addicts was transferred to government regulated private and public institutions.

Other factors that heightened the visibility of black drug offenders were; (1) Differential urban in-migration rates - the first World War and then immigration restrictions instituted afterwards cut off the flow of European immigrants into the United States. Blacks continued to move north as they had done throughout the war. New York and Illinois, New York City and Chicago, received the largest numbers. (2) Differential job allocation patterns - the jobs the newly arriving blacks took were the ones the European immigrants had traditionally taken. By any criterion, they were the worst jobs (3) Differential spatial location - early migration effects, income differences and effective residential segregation worked together to imprison blacks in central-city neighborhoods, while the white working class was able and chose to move out. It was in these neighborhoods that narcotics were to be found in this period, just as the trade in drugs had flourished when Jews and Italians, (etc.) had lived there in the teens of the century. The spatial displacement paralleled occupational displacement, and both are linked to the substitution of black for white narcotics users through the forties and fifties. The economics of ghetto housing insures that bad housing is profitable and that good housing cannot be maintained.⁵³ (4) Differential birth rates - the birth rate among blacks

arriving in the North during the thirties remained higher than among whites, notwithstanding a significant fall-off during the Depression. (5) Differential labor-market experience - the age of onset of narcotics use corresponds with the age of initial entry into the labor force⁵⁴ and since our understanding that severe labor would correspond with periods of increased narcotics use, it stands to reason that the higher the unemployment for teenagers, the more susceptible black teenagers will be to narcotics experimentation.⁵⁵

"The manpower problem of the urban ghetto appear best defined in terms of a dual labor market: a primary market offering relatively high-paying, stable employment, with good working conditions, chances of advancement and equitable administration of work rules; and a secondary market, to which the urban poor are confined, decidedly less attractive in all these respects and in direct competition with welfare and crime for the attachment of the potential labor force."⁵⁶

This is the institutional structure of labor market opportunity to which black teenage recruits must adapt. One of the adaptations is recruitment to crime as an alternative income source when labor mobility is blocked and when either the real return on labor in the secondary market decline (e.g. in periods of rapid inflation) or unemployment in that sector rises-or both. In this light, we identify recruitment to narcotics use as recruitment to the narcotics trade and industry, and an economically rational in these circumstances.⁵⁷

The evolution of the black addict is fueled by an unemployment rate among black teenagers of 41.6%, as of March, 1975. (U.S. Bureau of Labor Statistics) In some areas of New York City the rate is 60% and drug profiteer-

ing was directly related as a result of this staggering amount of unemployment. The close relationship between street-drug profiteering and use is highlighted by the fact that;

According to the Task Force Report: Narcotics and Drug Abuse, The President's Commission on Law Enforcement and Administration of Justice, Federal Bureau of Narcotics active addict data (1966 summary tables, unpublished) now shows that more than half of the identified opiate offenders are Negro (51.5 per cent), that 13 per cent are Puerto Rican, and that 5.6 per cent are of Mexican-American extraction. No matter what surveys on tables you use black, young male are the predominant known abusers. Any speculation about unknown is just that speculation. According to the Knapp Commission the area of the most police corruption is narcotics. Other forms of police corruption found by the Curran Commission are:

1. Directly selling heroin
2. Purchasing heroin from organized crime figures
3. Retaining heroin or money or both seized during a raid or search.
4. Providing protection to those engaged in heroin transaction, for payment either in money or stolen property.
5. Tipping of heroin violators of impending police raids and supplying other confidential information to heroin violators, again in exchange for money, heroin, or stolen property.
6. Interceding with brother police officers on behalf of narcotics criminals.
7. Attempting to bribe assistant district attorneys and other public officials in narcotics cases.
8. Committing perjury by giving false testimony in court in order to have a narcotics defendant acquitted, and presenting weak affidavits or complaints in order to bring about a lessening or dismissal of charges.

9. Falsely alleging undercover purchases of narcotics in order to retain some of the purchase money supplied by the police department.

Within this atmosphere of unemployment, drug profiteering and police corruption, treatment can never wipe out the heroin traffic, none of the treatment program's effect a net reduction in the number of addicts and that indeed narcotic substitution therapy may contribute to an increase in addiction by maintaining an addict pool of clients who may have otherwise matured out of the dependence syndrome. We can realize a net reduction in the number of addicts only if 51% of the clients receiving treatment remain drug-free. Evidence supporting the existence of such a methadone maintenance program cannot be found. Therefore, we can assume that since programs cannot effect a net reduction in the number of addicts, the clinics must be either containing the problem or showing the rate of growth of the addict pool.

Disciplinary social control allows program administrators to decide which clients may continue in treatment while co-optative social control allows them to determine how many clients may enroll.

"Society's failure to adequately cope with poverty and urban decay lays the groundwork for continuing the addiction problem".⁵⁸ "It is shown that in a world dominated by an elite, this (adopting certain scientific methods) can frequently bring about the political, social, and economic repression of a non-elite. It is concluded that the choice of scientific method does not produce unbiased results and that the dominance of a certain conception of scientific method leads to the scientific support of a viewpoint used to justify repression of the underprivileged in Society".⁵⁹

Black people are a repressed minority in America and that repression is continuing and being heightened on a daily basis. Any thoughts about the "progress of the Negro" are purely subjective and don't account for the objective reality presented in the following article of April 14, 1975, by William Clay of the Congressional Black Caucus. On the editorial page, he writes:

"Many blacks, to remain sane, no doubt grow up in America believing that discrimination and inequality illustrate more than a long-term historical event. There's a beginning and an end. Slavery, then emancipation; segregation, then a successful civil rights movement. Progress? Doubtless. But coming down from our euphoria, we've learned in the last eight years or so that some of the problems are a great deal more intractable (if soluble at all) than mere legal barriers to fundamental civil rights. Beneath that thin layer of courts and legislatures lay the whole American institutional infrastructure, resistant and poisoned to the core—universities and public school systems, businesses, city halls, labor unions, families and neighborhoods, police departments, fire departments, and on and on. The results are socio-economic statistical measurements that show our relative status in America as largely unchanged.

There has been no change and it appears there will be none in the plight of black Americans. The feelings and attitudes that dominate disadvantaged black communities are the outgrowth of a nation that turned a deaf ear to cries of poverty, inequality, injustice, alienation, war, racism, and other conditions that are inconsistent with human dignity. "It is as ancient as politics itself. Unpopular deviant minority populations have been clustered, labelled and segregated by political leaders for political purposes. They have been blamed for social ailments whose real sources are more deeply imbedded in the normative behavior of society".⁶⁰

Historically, heroin has played a unique role in the black struggle

for equal rights and democratic participation. There is some historical and current evidence to suggest that while the black communities have been struggling for community control, the government has been doing all in its power to maintain its corporate control over those communities. The issue of drug treatment has provided an important lever.

Drug programs treating minority persons fail to incorporate an understanding of black mental health. Black mental health is: (1) an inner drive to change the outer world (2) a deep distrust of white society - a minority person must protect himself against the physical hurt, humiliation, cheating and slander if his life is not to be unbearable. He trusts only those parts of white society which have proven trust worthy. (3) includes a degree of sadness - the minority person lives in spite of his abuse and knows misery well (4) a deep respect for minority moral codes which protect minority society (5) the honesty with which the minority person faces himself and his surroundings (6) freedom to act independently and to determine the minority future (7) the desire and ability to unite for the realization of common goals.

It is of interest that when asked during the third month whether they felt methadone maintenance would have to be a lifetime treatment program, only 18% of the black patients indicated this. On the other hand, 45% of the Puerto Ricans and 37% of the whites felt they would require methadone as a lifetime program.⁶¹ This survey gives support to an intuitive apprehension on the part of blacks toward methadone maintenance.

EVOLUTION OF "PREVENTIVE" SOCIAL CONTROL

Early in the 1960's, when blacks had become highly visible in central

cities, legislative mechanisms were being devised to synchronize with the shift in judicial perspective regarding addiction. The "penal" reform was aimed at restructuring the entry system by which addicts were to be funneled into the corrections system. In the 1963, Supreme Court decision of Robinson vs. California, addiction was declared a disease, not a crime. Being an addict, in and of itself was no longer a crime. But the ability of police to pull an addict off the street and subject him to criminal justice exposure for being an addict had not. Civil commitment procedures in several states preceded the Supreme Court decision and have been enacted in many states throughout the country. The civil procedures currently available to addicts, nationwide, are as follows;

"(1) patient initiated, but judicially - ordered commitment to a treatment program for a period of at least one month and frequently much longer (10 states) (2) judicial commitment, initiated by a third person and resulting in protracted, some times indeterminate confinement (34 states) (3) emergency apprehension and temporary custody not constituting an arrest, involving transportation of the person to treatment by either a public official or a private individual. (16 states) (4) Commitment to treatment as an adjunct to incompetency, guardianship or conservatorship proceedings (25 states)"⁶²

According to the report, persons against whom civil commitment petitions are filed are entitled to very few procedural safeguards, and the details in commitment vary from state to state. With so many conflicting opinions about the best method among many, it is quite difficult to understand enforced therapy. Thirty-four states have involuntary civil commitment laws and half (17) of these involve indefinite con-

finement. The commitment periods range from 30 days in Washington and Montana, to 10 years in California.⁶³

The strictest system is that of California, which is understandable, since it was the first enacted and faced the strongest opposition. It's system is located in the Department of Corrections. A minimum of six months of inpatient care is required with a maximum of ten years of parole-type, out-patient follow-up observation. Decisions on release and court recommendations are placed in the hands of a Governor-appointed board that is similar to a parole board and is a quasi-judicial body. Hence, we have quasi-judicial proceedings at both the entry and exit points of the system. What's worse is that California not only commits confirmed addicts but also "persons in imminent danger of becoming addicted".⁶⁴ This category is very difficult to apply - it is of questionable constitutionality as a grounds for civil commitment. This program was enacted in June 1961, in California and March 1962 in New York where the maximum commitment is three years. Massachusetts has civilly committed people to treatment for up to two years.

Characteristics of commitment procedures reveal the following: that in most states, commitment proceedings are conducted without a jury (as with most jails), the person can be detained pending a hearing without any kind of preliminary adjudication, and some states don't notify patients that the proceeding is being initiated. All these constitutional abuses in the name of treatment and there is no data directly comparing the criminal proclivities of opioid users with the general population.⁶⁵

Matthew P. Dumont, M.D., assistant commissioner of Drug Rehabilitation for the Department of Mental Health, Commonwealth of Massachusetts, has

described the phenomena as follows: "Civil commitment in its essence is an attempt to control or reject some individuals whom we despise while at the same time permitting us an illusory fidelity to a tradition of pluralism and individual autonomy. No more than Louis XV are we comfortable in prosecuting people for being unemployed, socially deviant, politically threatening or otherwise obnoxious. Civil commitment to institutions, it would seem, can serve the double purpose of removing an irritant and preserving our mythology of tolerance. It is a marvelous instrument of social control and has particular utility during times of social unrest and political instability when leaders can identify a scapegoat for a discontented public". (Richard Nixon learned his lesson well during the "Redscare" of the 1950's under Joe McCarthy).

As long as our communities and their courts find some people undesirable or threatening (though not criminal), then patients will be committed against their will to institutions which baptize incarceration with the term "treatment".

Criminal commitment procedures, nationally are characterized as follows; (1) pre-arrest, formally authorized diversion for purposes of detox or withdrawal. (8 states specifically so provide), (2) post-arrest diversion to detoxification (2 states), (3) treatment as a condition of pre-trial release (1 specifically, 27 others authorize conditional release on personal recognizance or to 3rd party custody), (4) emergency treatment while awaiting trial (6 states), (5) treatment in lieu of prosecution (at least 10 states), (6) treatment as a condition of deferred entry of a judgement of guilt and conditional discharge (32 states) or as a condi-

tion of suspension of sentence or probation (24 states), (7) treatment as a condition of parole (9 states), (8) commitment for treatment in lieu of other sentences, or while serving a sentence in a correctional facility or following administrative transfer from a penal institution (23 states).⁶⁶

According to the report, legal control over drug-dependent persons was established by the state and federal laws criminalizing the incidents of dependence, possession and acquisition. Until the 1960's, however control was asserted not for treatment but punishment.⁶⁷ I think the report is wrong and overlooked the covert possibility that medical services can be colluded into providing punishment and social control in the name of treatment.

The New York Times (1972) carried an interview which began: Dr. Jerome Jaffe said today that American Medical techniques, including "quarantine" now provide the means to "break the bank" of what he called the heroin "epidemic" in this country, much, he said, as the use of heroin by the military was curbed. Getting civilians to take tests and getting the ones identified as users to submit to the sort of detention and treatment imposed on military users raises civil rights problems, but Dr. Jaffe believes that with sufficient support from the media the public could be persuaded to support tests in schools and other institutions.

ROLE OF THE MEDIA

A great deal of drug reporting on major newspapers reflects ignorance, fear and false pre-conceptions because newspapers are most strongly interested in the sensational and/or dramatic aspects of drug "news" coverage. Stories of front-page dimension rarely characterize the day-to-day struggle experienced

by the majority of people involved with the drug traffic. Additional distortion due to excessive reliance on "official" sources of information, e.g. the local police, lack of cross-check facilities for stories, regional distortion, lack of a drug beat, and less than inspirational concern by the management contributes to the "mis-education" of the public. Rather than recognizing the seriousness of the problem, people appear to prefer to be entertained by the stories of drug trafficking and abuse.

Presidential crime commissioner Dr. William R. Corson believes that we have vastly underestimated the number of addicts that in fact there may be up to three million heroin addicts⁶⁸ of whom 80 per cent are black or members of a racial minority, and it is the youth of these racial minorities who are most affected and afflicted. And of course, it is the youth who are the most likely to develop a political consciousness to challenge the corporate status quo of America. Corson continues: There have been virtually no successful withdrawals from methadone after substituting it for heroin. And if for any reason the methadone addict is unable to stay on methadone, he is likely to return to heroin in a bigger way than before.

When a heroin addict switches to methadone, the heroin accomplices and distributing organization have lost a customer - a customer who needs and buys heroin seven days a week. This organization is not going to take a cut in their business. Every lost customer is going to be replaced. But with whom? Drug peddlers have made their market analysis and know where the sales resistance is low. So for several years they have been selling to younger and younger customers. This must be seen in the context of there being virtually no narcotics treatment facilities for youths under eighteen years

old, while at the same time the average age of the addict drops each year.

Black communities have been becoming increasingly rebellious since the Civil Rights movement in 1959 in general, and in particular with the burning of Watts in 1965. According to social scientist and author Michael Rossman: "By 1968 there were riots in 120 cities when Martin Luther King was assassinated. Then the trend of burning and rioting seemed to be reversed. But the reversal of this trend must have required more than multiplied military force and managed news to pacify ghettos". It is Rossman's belief that "the relative peace since then has been enforced by massive injections of heroin in the black main line. Before each long, hot summer and in each period of ghetto political tension, heroin becomes increasingly available to the ghettos. Addicts nod in doorways, people strengthen their locks in fear. Over 70 per cent of all ghetto crime is heroin connected.⁶⁹ The effect of all this injection of heroin is that the ghetto people's energies become absorbed internally, turned against itself, undermining all revolt against the external colonizing forces and the social conditions they have created.

Rossman continues: "The practice of drugging black ghettos with heroin seems to have begun seriously around 1967". The American Psychiatric Association reports that 'the extent of heroin use has grown wildly since the mid-1960's.' A long-time informer for the Los Angeles Police Department, whom the police publicly acknowledge as an informer, told The New York Times on October 24, 1971 that 'the police had allowed and encouraged narcotics to be sold in black and Chicano communities to create a dependency on heroin and undercut political movement.' Obviously the price of

of police corruption is dying neighborhoods, a whole generation of lost children, and subterfuge of any youthfully energized political momentum.

Of course, police addiction corruption is not restricted to California or New York State. According to David Burnham of the New York Times: "Police corruption involving the selling of heroin has been uncovered recently in police departments and sheriffs offices in at least 23 states and the District of Columbia". It is my belief that there is extensive corruption in almost every major and many medium-sized police departments in the United States. I am convinced that official investigations are a poor index of the size of the corruption problem.

Another article by Burnham, in the New York Times, states "that the number of addicts in New York City alone went in 1967 from 90,000 to its present level of 400,000". That the epidemic is politically inspired is suggested by many facts now emerging about the heroin trade.

With the great increase in the number of addicts, there has been a concomitant increase in the number of addict-related crimes. This increase in the number of crimes has been used as an argument for police forces to expand enormously, to function in the ghettos as occupying forces, and to organize and affiliate for independent political power - in spite of the fact that very few addicts commit crimes of violence. The addicts tend to be sneak thieves, shoplifters, and lush rollers.⁷⁰ To the extent that the present balances and policies of power in this nation at least appear to depend on wide and spreading heroin use, by the blacks, particularly young blacks, the "mystification" of abuse has been responsible for a 40 percent increase in drug funds appropriated in just one year.⁷¹

Black Panther and former addict Michael Tabor calls heroin a "plague of epidemic proportions in the black community, and still growing. Despite supposedly stiffer jail sentences that are being meted out to those whom they define as being 'drug profiteers', and that term is nothing but a euphemistic way of saying 'illegal capitalists', there are more dope dealers now than ever before despite the increasing number of so-called rehabilitative and preventive programs, the plague proliferates and threatens to devour an entire generation of youth. Capitalism plus heroin equals genocide". Tabor notes that, "The basic and fundamental reason why the heroin plague cannot be stopped by the drug prevention and rehabilitation programs is that these programs, with their middle-class, archaic Freudian approach and group therapeutic concepts do not deal with the ultimate root causes of the problem.

These programs deliberately negate the politico-economic origins of drug addiction. These programs sanctimoniously deny the fact that capitalistic exploitation and racial oppression are the main contributing factors to drug addiction. Since the programs are funded by the rulers of the capitalistic system, the programs could never be geared to turn the people against the ruler's system."

The government has no desire to address itself to the true causes of addiction, for to do so would necessitate making fundamental and basic institutional and structural changes. These changes could not take place, they could not possibly be effected without changing the manner in which property is owned and the manner in which wealth is distributed in this society. In short, only a revolution could eliminate this genocidal plague!

"Heroin use today by lower class, primarily minority-group persons does not provide for (us) them a euphoric escape from the psychological and social problems which derive from ghetto life. On the contrary, it provides a motivation and rationale for the pursuit of a meaningful life, albeit or socially deviant one."⁷² What the addict doesn't realize is that he is buying death on the installment plan.

Under the guise of ridding the ghetto of dope, demagogic politicians on Capital Hill passed a "no-knock" law, which gives narcotics agents a right to crash into a suspected dope dealer's house without knocking, if there is reason to believe that drugs may be destroyed. As if five pounds of heroin or cocaine could be flushed down the toilet, without a trace. As Tabor says, "Anyone who thinks that this law will be confined to just suspected dope peddlers is negating the fact that this country is becoming increasingly repressive, especially as its most oppressed people in all our ghettos become more politically conscious. It should come as no surprise when the homes of revolutionaries and other progressive individuals are invaded by police under the pretext of searching for narcotics. A number of black revolutionaries have already been imprisoned on trumped-up narcotic charges, for example Martin Sostre, sentenced to 41 years. You can rest assured that this policy will be intensified. When the police kick in a revolutionary's door, and crash through the windows with shotguns on the pretext of looking for drugs, they will find drugs because they bring them with them".

In an article entitled, Losing the Narcotics War, Washington Post, (March 30, 1975), Jack Anderson says: in effect The United States in

losing the war on narcotics because of ineffective programs, bureaucratic jealousies, diplomatic timidity and a mushrooming demand....Heroin abuse, according to the latest federal estimates which have been meticulously suppressed by the Washington bureaucracy is at an all-time high. An estimated 125,000 new addicts because hooked in the past year alone combined with other drug abuse the flood of illegal narcotics has reached a higher level than the 1971-72 peak. The stark truth is that America is in the throes of a heroin epidemic. Yet no one seems to know how to handle the problem. New efforts were made to crack down on drug pushers and smugglers. Four rival narcotics agencies, which had been fending with one another, were merged into the single Drug Enforcement Administration. But instead of stopping the fend the reorganization simply brought them under the same roof. In a series of columns, we have shown how the nation's top narcotics officials have been so busy investigating one another that they have had little time to cope with the dope peddlers. Some critics of the enforcement effort have charged that all the arrests have been made at lower levels and that the ringleaders seem to be able to continue in business untouched. In summary, the narcotics epidemic in America continues unabated despite federal education, assistance and enforcement programs totaling almost three-quarters of a billion dollars. A rather pessumistic outlook on the efficacy of enforcement to curtail heroin addiction in America.

ADDICTS AND CRIME

The media image of the violent, theiving dope fiend has been useful in proseltyzing stong law enforcement reaction to addicts and in generating public support of such measures. The national media must share a responsi-

bility for this misrepresentation. A great deal of drug reporting on major newspapers reflects ignorance, fear and false pre-conceptions. Approximately 99% of all reporters covering drug abuse are white, middle-class journalists. Newspapers and newspaper reporters are most strongly interested in the sensational or dramatic aspects of drug abuse to sell papers. There is excessive reliance on "official" sources of information, e.g. local police. Reporters seldom cross-check stories on the street and portray certain regional bias in their reporting. Therefore, it is difficult for the general public to develop a clear understanding of the nature of addiction and its relation to crime.

"The question whether the illicit activity engaged in by heroin-dependent persons is representative solely of the economic need to obtain heroin or whether it is partially independent of that need has been the subject of discussion on many different occasions. Pescor and Vogel have shown that 60-75% of addicts have been free of any criminal record before their addiction. Auslinger, on review of 2,268 narcotics violators, found that 67% had criminal records pre-dating their addiction. More recent evidence has indicated that the first incident of illegal activity, as found in probation records, predates the onset of the history of drug use by one to two years."⁷³ It is quite difficult to develop any meaningful figures for the actual crime rate among addicts. Interestingly enough, in 'England' a causal relationship between narcotics addiction and criminal behavior has not been found.⁷⁴ According to the F.D.A., 50% of the nine billion barbituates and amphetamine capsules and tablets manufactured annually in this country are diverted to illegal use.⁷⁵ Who's watching the pharmaceutical industry?

MYTH OF THE PUSHER

The network of friendships through which drugs are distributed renders buyers and sellers indistinguishable,* except when institutional racism operates as you go up the distributive scale. A New York City Addiction Services Administration survey of 1,166 patients revealed:

52%	drugs by friend of same age
33%	drugs by friends of older age
3%	drugs by relatives
3%	drugs by pusher

Any attempts by police officers to separate buyers and sellers with differential legal penalties must be seen as unrealistic. *In 1970 average sentences in Federal prisons for income tax evasion for whites was 12.8 months, while blacks, 28.2 months. The average sentence for drug abuse for whites was 61.1 months, for blacks 81.1 months. And all authorities related to drug enforcement will agree that whites control the distribution system. On page 1 of the September 18, 1975 Boston Globe the Justice Department let it be known that it has uncovered evidence linking Drug Enforcement Administration (D.E.A.) officials and agents to crimes ranging from murder through blackmail, smuggling, extortion and black marketeering in drugs and gold. There were also confirmed reports that informants were paid off with heroin and other drugs seized by D.E.A. agents in earlier raids. The destruction between buyer and seller is obviously more complicated than the image projected in the media particularly when paid informants, undercover agents and international couriers of organized crime are involved.

CARROT OR THE STICK

It is obvious that the proverbial "carrot or the stick" arrangement is being orchestrated by closely intermingling factions of medicine and law.

The addict, in most instances, is either being asked to submit to indefinite treatment on a form of narcotic similar to the one he was already taking or go to jail. The control is either physical via "isolation" or mental via enforced therapy, neither of which has been proven to have any long-term effectiveness. The co-optative social control, characterized as the professional management of people's lives, is exerted through medical services as social workers, probation officers, counselors, etc, who monitor in-community behavior by direct observation, interview and urine screening. A great deal of value-imposition is applied during this form of restriction. The disciplinary social control is exerted by enforced maintenance treatment which directly ties you in and out of community behavior to your continued access of the drug. You may have to submit rules and regulations of questionable constitutional validity, which you had no part in designing. Furthermore, behavior deemed unacceptable by the staff may result in your immediate termination without benefit of detoxification.

URINALYSIS SURVEILLANCE

Urinalysis surveillance is already a familiar component of methadone programs. It has important implications in determining "cure" rates and successful community entries by newly released addicts on probation or parole. According to an article in the New England Journal of Medicine, October 5, 1972 Vol. 287 no. 14, page 23-24, "Error rates on unknown samples commonly run as high as 20 to 70% according to unpublished data of the Contra Costa County Probation Department and State of California Department of Corrections. The "micturition observers" represent police state tactics par excellence. Realistically speaking for growing numbers of

people, internal possession of a drug is against the law. It is recommended that officials in government, industry, labor, academia, etc., rather than the enlisted man or some filing clerk some where be tested. (in Urine Screening: Chemical McCarthyism by G.D. Lundberg, Univ. of South Carolina, School of Medicine.)

NATIONAL IDENTIFICATION

All states that accept federal funds for treatment must assign a "unique identifier" code to every client who applies for treatment. This identification procedure is a condition of the continued receipt of funds and is monitored by the staff of C.O.D.A.P. - Client-Oriented Data Acquisition Process. "The only methadone available for addicts will then be through those programs approved and supervised by the government. C.O.D.A.P. is the technical mechanism for monitoring the patients themselves."⁷⁶ Footprint or voice print systems and a nationwide registry of addicts are under consideration. The "epidemic" mentality fostered by politicians and the media deny the fact that "each decision to use the drug, even after physiological addiction, is a conscious decision chosen from alternatives."⁷⁷ The communicable disease theory has the particular danger of providing a theoretical background for politically expedient action, which may thus accord it more validity than it deserves."⁷⁸ Dr. Jaffe, when he was at S.A.D.D.A.P. has frequently emphasized the need for large-scale effort to identify civilian addicts and impose treatment upon them. Urinalysis, psychiatric speculation and civil commitment make it possible and it is currently in operation in pilot programs throughout the country. The the Journal of Addiction Research Foundation 1972, Dr. Jaffe recently announced

his T.A.S.C. program (Treatment Alternative to Street Crimes) which develops a specialized identification, referral and monitoring system which uses the arrest as an event that opens door to treatment.... This process will bring into the treatment system those who would not enter it voluntarily".

"As an instrument of social control and to be politically expedient, enforced therapy/civil commitment requires several pre-requisites;

- (1) The target population should be small enough to be conspicuous
- (2) The behavior of that population should be offensive to good taste and decorum
- (3) There should be no major constituency, vested interest or advocacy for the target population.
- (4) There must be a group of professionals who are willing to minister to civilly committed without questioning too deeply the purposes of that commitment. The more complex and esoteric their techniques the better. Especially if it implies incarceration, whatever form.
- (5) There must be mechanisms for identifying and monitoring the target population whether or not they are actually institutionalized. Civil commitment is about to find its most perfect realization in the control of addiction as American democracy approaches its third century."⁷⁹

POLICY RECOMMENDATIONS

I would request that all methadone maintenance be closed immediately and that clients currently being maintained be detoxified and that no new patients be admitted. I would lobby for legislation that would restrict methadone use to detoxification exclusively and redirect administrative control of the majority of programs to community residents. Hospitals would only be used for complicated medical withdrawals and as back-up facilities for general physical examinations. The only alternatives available to

addicts would be detoxification withor without methadone, and residential therapeutic community living. Abstinence-oriented programs offer diversification of structure and philosophy due to differing geopolitical affiliation and therefore addicts would have a variety of options to choose from for their own, self-initiated attempt at "cure".

The programs I envision, rather than emphasize group therapy or methadone, would be advocacy institutions for the addict that would engage people around the viable and workable tenets of political education. These programs would be indigenous and community-worker controlled. One such program is the Lincoln Detox Program. While the program's medical function is acute detoxification (withdrawal) from heroin, it provides a model for changing an entire community politically, rather than simply "maintaining", "de-criminalizing", and "sanitizing" addicts.

The program is located in the South Bronx and was formed by a number of local revolutionary organizations, specifically the Black Panther Party, the Young Lords, and the Health Revolutionary Unity Movement. It was their sense that to do any political organizing in the drug-infested South Bronx, they had to confront drugs, and to confront drugs meaningfully on a community-wide basis the confrontation and program must be political. Heroin controls significant portions of virtually everyone's life in the South Bronx.

Because heroin law-enforcement agencies have institutionalized both the criminal traffic in the drug and the use of it as but one response to the insanity of America, revolutionary groups, rather than making a psychological analysis of the addict, developed an institutional and political analysis of the addict and his/her community. The political analysis states

that addiction occurs not because of a certain "personality type" or a "conflicted oedipal complex" or ingratiated dependency needs" but rather, according to one of the advising organizers in the program: "Addiction is a market response to economic dislocation and class antagonisms. Under capitalism, large corporations, legal and illegal, struggle to evolve and through control of product and marketing techniques, determine through what channels need shall be directed to feed. In a corporately controlled society the consumer is corporately directed. Thus needs can be channeled into markets which can relate satisfaction to specific products. "Addicts can be seen as a potentially revolutionary group. Addicts are a lump in class—they don't produce anything but crime... Addicts have a keen sense of hardship and they must stay away from the police". Political organizing efforts then take the form of bringing political consciousness to the addicts keen sense of hardship and explain why both the addicts and the organizers "are fighting the cops".

Lincoln Detox is joined by R.A.P Inc. of Washington D.C., headed by former Plack Panther Ron Clarke, and Uhuru Sasa House in Oakland, CA. in developing a political education base for therapeutic intervention.

Drug abuse is an institutional issue and consequently, cannot be understood or dealt with as if it were caused by individual weakness, deficit, shortcoming or pathology. From this perspective, one can view service delivery as a means to develop distinct, new ideological and political constituencies.

* I would like to extend thanks to Steven Freels, counselor/consultant currently working with Training and Development Systems for his time related to this interview.

The availability and provision of federal money is not the primary issue in effectively combating drug abuse. There will never be enough money provided to cope with the problem. In 1970, Congress noted a 167 billion dollar budget. Of that amount, 63.7% went for military and defense related priorities. Only 18.2% of the total budget allocated for "human needs at home (Washington Newsletter March 1971).\" It would be folly to assume that any administration would totally reverse those figures and/or priorities.

Effective social change is a process requiring both the mastery of a variety of different intervention strategies and the knowledge of how and when to utilize any one (or a combination) of these strategies. Hence, the short and long-range goal of any "human renewal" effort must be to increase the probability that poor people, both as individuals and as a class, can become more self-determining of their lives and in much greater control of the resources that currently both define and control their existence.

Poverty is the absence of money and consequently, the inability to both possess the goods and acquire the power needed to survive and/or be a reasonably self-determining member of a super-industrialized and acquisition oriented society. Poverty is the cause of addiction, and social problems its consequence. Upon questioning a patient at the Boston City Hospital Methadone Maintenance Program, largest in Boston, about the program he said, " I know about methadone, what I knew about Watergate - it's all part of the source conspiracy".

The following recommendations can be applied to the drug "problem" and form the basis of a sane drug policy.

First, laws against the possession and sale of marijuana should be repealed and a system of government-regulated sale to persons eighteen and over should be established. Second, all laws which make it a crime to use drugs or to possess drugs for personal use should be repealed. Civil commitment should be abolished. The government should abandon its efforts to force other countries to curtail opium production and should reduce its investment in border surveillance and enforcement activities. The money thus saved could be better used to provide treatment programs, jobs, vocational training and other supportive services to persons suffering from drug problems. Legal protection for addicts in maintenance programs should be enacted and addicts be brought more into the design and administration of programs to help addiction.

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- 20) 1-alphaacetylmethadol is currently under investigation at Boston City Hospital with Dr. Vernon Patch, the director of methadone maintenance, as principal investigator. laam is a synthetic, oral narcotic, that only has to be administered once every 2-3 days rather than once a day with methadone. Memo from Human Studies Committee, Boston City Hospital.
- Naltrexone is a narcotic antagonist currently classified as an investigational drug by the F.D.A.

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- 21) Martin, William R., "Commentary on the 2nd National Conference on Methadone Treatment, p.200
- 22) _____, Maturing Out of Narcotic Addiction in New York City, International Journal of the Addictions, 8(2) 1973 p. 921
- Further evidence of this phenomena is presented by George E. Vaillant, M.D. in "The Natural History of Narcotic Drug Adiction" Seminars in Psychiatry, Vol. 2, No. 4 (November) 1970
- 23) Casriel, Daniel, M.D., testifying before the House of Representatives, Select Committee on Crime, Hearings, 92nd Congress, 1st session 1971, part 1, pp 296-297
- 24) Letter to the Editor, Journal of the American Medical Assoc. Vol. 2 No. 6, Feb. 11, 1974, p. 660
- 25) Nelkin, Dorothy, as cited p. 6
- 26) Ibid. p. 8
- 27) Brecher et al p. 142
- Information on the early development of the methadone program and its structure is available in numerous articles, including; Vincent Dole, M.D., "In the Course of Professional practice," New York State Journal of Medicine, 65(April 1, 1965), 927-931; Vincent P. Dole, M.D. and Marie Nyswander, M.D., "A Medical Treatment for Diacetylmorphine (Heroin) Addiction," Journal of the American Medical Association 193(August 23, 1965), 646-650; Vincent Dole, M.D., "Methadone Maintenance Treatment for 25,000 Addicts," Journal of the American Medical Assoc., 215(February 15, 1971) 1131-1150, Marie Nyswander, M.D., "The Methadone treatment of heroin Addiction," Hospital Practice, 2(April, 1967); Vincent Dole and Marie Nyswander, "REhabilitation of Heroin Addicts after blockade with Methadone," New York State Journal of Medicine, 66(August 1, 1966) 2011-2017.

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28) Brecher et al, p. 153

29) Quoted in Nat Hentoff, A Doctor among the addicts, (New York: Grove Press, Evergreen Black Cat. ed. 1968), p.44

30) Nelkin, Dorothy, as cited, p.42

31) DeLong, James V., The methadone habit, New York Times, March 16, 1975, p. 16/section 6

32) Gardiner, Raymond and Connell P.H., " One years experience in a Drug dependence Clinic," The Lancet, August 29, 1970, pp. 455-458. Also see Richard Phillipson, "Methadone Maintenance: Some Uses, Some Limitations, Some Dangers," International Symposium on Drug tolerance, Addiction Abuse, and Methadone Treatment, New Orleans, August 17, 1971 (mimeographed)

33) Statement by Congressman Charles Rangel, Select Committee on Crime, Hearings July 1971

34) Reported in New York Times, Dec. 13, 1971.

35) Quoted from Brecher et al, p. 163.

36) Ibid. p 168

37) Ibid. p. 164

38) Ibid. p. 168

39) From the Drug Abuse Council, Annual REport, 1973, p. 4

40) Nelkin, Dorothy, as cited, p. 51

41) Dole Vincent P., in Proceedings, Second National Methadone Conference, p.54

42) Editorial in Journal of American Medical Assoc, Oct. 2, 1972

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- 46) Brecher et al, Table I, Classes of Opium Users 1889, p. 19
- 47) Quoted from C.E. Terry, Annual Report, Board of Health, (Jacksonville Fla., 1913), in Brecher, et al., p. 18
- 48) Helmer, John and Vietorisz, Thomas, Drug use, the labor market and class conflict, Research Center for Economic Planning, unpubl. paper, p. 31
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- 64) _____, New England Journal of Medicine, (August 6, 1964) Vol.1271 page 310
- 65) 2nd Report Nat'l Comm., Vol. I, Technical Papers. p263
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- 68) Count discrepancies occur because 1) underreporting is a characteristic of an illegal practice, 2) Registry data only report cases that come to attention of certain agencies, 3) The quality of reporting techniques varies, usually improving over time, 4) panic responses inflate or deflate estimates according to situational expediency, 5) estimates may be distorted through political and historical black undercounting. See also, Lavenhar, Marvin A. The Drug Abuse Numbers Game, and Singer Max, Addict Crime, The vitality of Mythical Numbers.

- 69) According to a survey of Harlem conducted by the Small Business Chamber of Commerce, 51 per cent of Harlem's residents have been mugged, where 70 per cent of those assaults were by known addicts. Ninety per cent of all businesses in central Harlem have been robbed or pilfered-again primarily by addicts.
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